| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 215121 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Snow Hill Rehabilitation & Healthcare Center | 430 West Market Street<br>Snow Hill, MD 21863 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>50504<br><br>Based on interviews and facility record reviews it was determined that the facility failed to ensure that facility records for abuse and neglect were maintained for correction of alleged violations and completed investigations. This was found to be evident for 3 (Resident #18, #28 and #219) out of 5 Residents reviewed for investigation and correction of alleged violations of abuse and neglect.<br><br>The findings include:<br><br>1. On 2/19/25 a review of the Facility Reported Incident (FRI) MD00189291 revealed that on 2/21/23, Resident #170 was observed in the room of Resident #18 with their hand on the clothed thigh of Resident #18. The incident was reported to Office of Health Care Quality on 02/23/23.<br><br>The summary of the incident stated that Resident #18 was assessed and was not negatively impacted by the incident. Resident #170, had a diagnosis of Dementia and was adjusting to a new environment. Him/her had medication changes and the facility worked to find the correct medications for him/her. After the incident, Resident #170 was placed on 1:1 sitter observation until a psychiatric evaluation was completed. Subsequently, Resident #170 was discharged from the facility on 04/14/23.<br><br>On 02/19/25 at 9:33AM a review of Resident #18's clinical record revealed diagnoses including Reduced Mobility and Muscle Weakness, a BIMS score of 13 of 15, cognition intact (Brief Interview for Mental Status, BIMS, is a screening tool used to assess basic cognitive function in patients in long-term care facilities.)<br><br>Further review of Resident #18's clinical record revealed that the facility did not investigate the incident.<br><br>On 02/19/25 at 11:30AM in an interview with the surveyor, Resident #18 could not recall the incident.<br><br>On 02/20/25 at 09:10 AM in telephone interview with the surveyor, Resident #18's Responsible Party stated that that he was informed by the facility of the incident and was satisfied with the way the facility handled the matter. He did not have any concerns regarding Resident #18's care.<br><br>The surveyor conducted several interviews with staff members on 02/20/25 regarding the incident. The staff members stated that they had no knowledge of the incident.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 02/19/25 at 01:00 PM the surveyor asked the Nursing Home Administrator (NHA) for the FRI investigation regarding the incident. The NHA did not provide the surveyor with the documents, he stated, I cannot find it. Further, the NHA stated that he was not employed at the faciity at the time of the incident and did not know whether the incident was investigated.<br><br>48393<br><br>2. On 2/21/25, a review of the Facility Reported Incident (FRI) MD00204342 revealed that on 4/4/24, a staff member observed Resident #28's family member grab Resident #28 in the area around his/her neck after he/she refused to give the family member a kiss.<br><br>On 02/21/25 at 9:05AM, the surveyor requested the facility's investigative file for the reported incident that occurred with Resident #28 on 4/4/24.<br><br>On 2/21/25 at 10:37 AM, an interview with the Nursing Home Administrator (NHA) conducted to reveal that the NHA started working at the facility in 8/2024 and was not able to locate the facility's investigation report for Resident #28's alleged incident on 4/4/24. The NHA further stated that he reached out to the previous administrator and was still not able to locate the facility's investigation report for the alleged incident involving Resident #28 on 4/4/24. The NHA stated that he would keeping looking for the report.<br><br>On 2/21/25 at 11:01 AM, an interview with Activities Aide #44 revealed that she witnessed the incident that happened with Resident #28 and his/her family member on 4/4/24 and stated that she reported the incident to her immediate supervisor and the NHA at the time.<br><br>During a follow up interview with the NHA on 2/21/25 at 11:39 AM, the NHA stated that he was not able to locate the facility's investigation report for Resident #28's alleged incident on 4/4/24.<br><br>On 2/21/2025 at 12:47 PM, the facility's abuse policy titled Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation was reviewed. The policy stated the facility will investigate and document all incidents and accidents involving residents.<br><br>At the time of the exit conference, the facility did not provide any additional evidence to show that a thorough investigation was conducted for Resident #28's alleged incident of abuse.<br><br>49815<br><br>3. On 02/19/2025 at 09:57 AM the surveyor interviewed and requested from the Nursing Home Administrator (NHA) the facility investigation file for the Facility Reported Incident (FRI) - MD# 00191752 that the facility Nursing Home Administrator (NHA) reported to the Office of Healthcare Quality (OHCQ) on 04/28/2023 at 09:34 AM for Resident #219. The NHA stated that he would look for the facility investigation file as he was not the NHA in April of 2023 at the time that the Facility Reported Incident (FRI) was reported to the Office of Healthcare Quality (OHCQ).<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The surveyor reviewed the facility's abuse policy - Abuse, Neglect, Misappropriation of Resident Property, Suspicious Injuries of Unknown Source, Exploitation and Sexual Consent, Relationships, and Capacity Assessment on 02/19/2025. The policy indicated that the facility would conduct a prompt investigation of any allegation received of suspected abuse, neglect or exploitation or mistreatment, including injuries of unknown source and misappropriation of Resident property. In addition, the policy indicated that the facility staff were trained on hire, on regular intervals and periodically if the facility management believed that the staff understanding of the policy was deficient.<br><br>According to the report filed by the facility with the Office of Healthcare Quality (OHCQ) on 04/28/2023 at 09:34 AM for Resident #216 the report indicated that the Director of Nursing (DON) was going to conduct an in-service with staff on abuse and neglect.<br><br>Follow-up interview with the Nursing Home Administrator (NHA) on 02/20/2025 at 11:45 AM, the surveyor again requested the facility investigation file for Resident #219 and the NHA stated that he was unable to locate the investigation file for the Facility Reported Incident (FRI) for Resident #219. The NHA further stated that he contacted the former NHA of the facility and the former owner of the facility, and the facility investigation file was not located for Resident #219. In addition, the facility had no documentation that in-services had been conducted with the facility staff on abuse and neglect.<br><br>At the time of the exit on 02/21/2025 at 01:30 PM the Nursing Home Administrator (NHA) was not able to provide a facility investigation file or documentation of in-services for facility staff on abuse and neglect for the Facility Reported Incident (FRI) for Resident #219 that was reported to the Office of Healthcare Quality (OHCQ) on 4/28/2023 at 09:34 AM by the prior NHA of the facility. |